STATE OF RHODE ISLAND & PROVIDENCE PLANTATIONS
Department of Administration – Office of Employee Benefits
Phone: (401) 222-3160 Fax: (401) 574-9281

HEALTH COVERAGE ENROLLMENT / STATUS CHANGE FORM

☐ **New Hire** ☐ **Open Enrollment** ☐ **Qualified Status Change** ☐ **Name/Address Change**

1. EMPLOYEE INFORMATION – *Please print clearly and legibly.*

NAME: (First, MI, Last) | SSN: | HIRE DATE:

ADDRESS: (Street, City, State, Zip) | PHONE: ( )

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partnership | DOB: | SEX: ☐ M ☐ F

2. QUALIFIED STATUS CHANGE

Event Date:

Supporting documentation must be submitted for all status changes within 31 calendar days of the occurrence of the status change event. See form instructions for further information on status changes and effective dates.

☐ Marriage ☐ Domestic partnership begins/ends ☐ Divorce ☐ Death ☐ Birth/Adoption ☐ Loss of coverage

☐ Change from full-time to part-time employment or vice versa for you or spouse/domestic partner ☐ Commencement or return from an unpaid leave of absence for you or spouse/domestic partner ☐ Employment begins or ends or open enrollment period for spouse/domestic partner ☐ Compliance with certain domestic relations orders or decrees

3. MEDICAL/Rx COVERAGE ELECTION – UNITEDHEALTHCARE/CVS CAREMARK

Choose 3A or 3B below. You must attach the Medical Waiver Form if waiving medical/Rx coverage. You must attach the Optum Bank HSA Application if enrolling in the Choice Plus Plan with HSA.

3A. 2014 ACTIVE EMPLOYEES HEALTH PLAN CHOICE PLUS

☐ Enroll ☐ Change ☐ Waive ☐ No Change | ☐ Individual Plan ☐ Family Plan *(Must complete Section 6 Dependent Info)*

3B. CHOICE PLUS PLAN WITH HEALTH SAVINGS ACCOUNT (HSA)

☐ Enroll ☐ Change ☐ Waive ☐ No Change | ☐ Individual Plan ☐ Family Plan *(Must complete Section 6 Dependent Info)*

4. DENTAL COVERAGE ELECTION – DELTA DENTAL OF RHODE ISLAND

☐ Enroll ☐ Change ☐ Waive ☐ No Change | ☐ Individual Plan ☐ Family Plan *(Must complete Section 6 Dependent Info)*

5. VISION COVERAGE ELECTION – VISION SERVICE PLAN (VSP)

☐ Enroll ☐ Change ☐ Waive ☐ No Change | ☐ Individual Plan ☐ Family Plan *(Must complete Section 6 Dependent Info)*

6. DEPENDENT INFORMATION – ***Copy of marriage certificate must be attached to add any spouse. Completed Affidavit of Domestic Partnership and Domestic Partner Dependent Declaration Form must be attached to add any domestic partner. Copy of birth certificate must be attached to add any dependent child.***

Check One: Enroll	Drop	Name (First, MI, Last)	Relation*	Dependent SSN	Sex M/F	Birth Date MM/DD/YY	Full Time Student**
☐	☐						☐
☐	☐						☐
☐	☐						☐
☐	☐						☐
☐	☐						☐

*Relationship: **S**=Spouse **C**=Child **DP**=Domestic Partner

****Proof of full time student status required for dental and vision coverage for any dependent child between ages 19 and 25.

7. DUAL STATE-EMPLOYED SPOUSES DECLARATION – Are both you and your spouse state employees? ☐ Y ☐ N

If you checked the "Y" box, you must complete and attach the Dual State-Employed Spouses Declaration Form.

8. EMPLOYEE APPROVAL AND AUTHORIZATION – *Please read and sign below.*

I certify that the above information is true and correct to the best of my knowledge. I understand that my elections are irrevocable during the plan year and that I can only change my election(s) during open enrollment or within 31 days of a qualified status change. I authorize the deduction of the appropriate co-shares from my wages, and agree that should I have an unpaid leave of absence from my employment I shall be responsible for direct remittance of my co-share payments or risk termination of my coverage with 30 days' notice. Should I return from a leave of absence with an unpaid co-share debt, I authorize my employing agency to deduct the balance of my debt through additional payroll deductions over time in amounts not exceeding my standard co-share deduction amount per pay period. Should I leave state service with an unpaid co-share debt, I authorize my employing agency to deduct the balance of my debt from any accrued vacation and/or sick time pay out.

Employee Signature: Date:

The Rhode Island State Employee Health Plan complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Language assistance services, free of charge, are available to you. Call (401) 222-3160.

TO BE COMPLETED BY AGENCY HR STAFF:

Rev. May 2017

Union Code: _____ Payroll Account Number:_____